Testimony Presented to the Michigan House Insurance Committee
Regarding House Bill 4936
October 11, 2011

Thank you Mr. Chairman, members of the Committee. My name is Mark Lemoine and I'm the Director of Government Affairs for Spectrum Health System in Grand Rapids. Spectrum Health is a not-for-profit integrated health system operating nine hospitals in West Michigan, a multi-specialty physician group with over 500 doctors and a health plan, Priority Health, providing individual, group, Medicaid and Medicare insurance products to more than 600,000 Michigan residents across the state. I am joined today by Andy Johnston, V.P. of Government Affairs for the Grand Rapids Area Chamber of Commerce and my colleague Larry Oberst, V.P. of Finance for Spectrum Health Continuing Care.

Since the introduction of House Bill 4936 just shy of one month ago, we are pleased to have the opportunity to formally review this legislation and engage in the discussion regarding proposed reforms to auto no-fault in Michigan. The Committee has heard from those on both sides of the issue. Rather than reiterate statements you have already heard, our objective today is to reinforce a few points and provide a better understanding of the financing dynamics that occur within the health care industry – in particular the issue of the "cost-shift." (*please draw attention to Power Point illustration*).

First and foremost, health care organizations are businesses. Like all other businesses, our operations create fixed expenses. In the case of health care, those expenses are heavily attributable to the people we employ and the costs associated with the equipment and supplies necessary to care for patients. Those expenses establish our cost of doing business.

As a not-for-profit health care system, while we are not in business to specifically make a profit, our expenses must stay in line with our revenue. Therefore, payment for our services must be in excess of our costs. The for-profit business world calls this "profit." In the non-profit world, we call that "margin." Failing to achieve a healthy margin is not a long-term strategy for any business. It would of course jeopardize our financial viability and hinder the availability of our services, just like any other business.

Another aspect that makes our industry unique is that while everyone uses health care services, very few people pay for our services directly. Instead, our country has developed a system where most of us have a third-party (insurance carrier) pay for the services we receive. Furthermore, health care is unique from most businesses in that we also serve customers who pay us nothing at all.

The issue of the cost-shift begins with the determination of our rates (a.k.a. charges). Our rates are the fees we charge those individuals or groups that actually pay for our services. Charges always start at the same amount for ALL payers. But just as with any business, payment plans can be, and are negotiated with individual patients who pay cash for our services or with insurance companies that manage the health care needs of a large volume of people, typically through employer-sponsored health care benefits. The final element needed to illustrate the "cost-shift" is adding third-parties that don't negotiate their payments, but dictate them to providers. I'm speaking of the government insurance programs of Medicaid and Medicare.

As you will begin to see on the illustration, uninsured patients, who often have little or no financial means available, pay us nothing for our services. Michigan's Medicaid program pays on average only 70 cents on the dollar of our costs, and Medicare pays on average 95 cents on the dollar of cost. Fee schedules, like workers compensation, also dictate the payment or use a formula that is at or only slightly above our costs. For Spectrum Health specifically, this amount of uncompensated services resulted in $176.5 million in community benefit in FY 2011. The break down includes:

- $104 million spent on caring for patients in government programs in our hospitals
- $37 million spent on caring for the uninsured and underinsured who don't pay their medical bills
- $13 million spent on traditional charity care, which covers services for patients who cannot afford to pay anything due to their lack of income and assets, and
- Nearly $23 million spent on programs caring for the underserved, operating health clinics and funding medical research.

Therefore, in order to sustain health care services that are designed to meet the health care needs of the communities we serve, approved by our local business leaders serving on our community board of directors, and in some instances overseen by the Michigan Certificate of Need Commission, our overall costs must be paid for.

In West Michigan we have been completely transparent and worked very closely with the business community regarding the dynamic of the cost-shift. Understanding that 59 percent of our uncompensated services come from government programs, we even refer to this as a "hidden-tax." This is because over the past decade the state government has often balanced its budget by making significant cuts to the Medicaid payments it makes to health care providers. A perfect storm also has hit health care providers relative to the state's economy, which resulted in nearly a 100 percent increase in

the number of our citizens being added to the Medicaid rolls, often as a result of losing their jobs and the employer-sponsored health care benefit that came with it.

As a business, health care providers cannot make up the losses we incur when treating a greater volume of patients who pay nothing or are on government programs that make payments that do not even cover the costs of the services provided. Therefore, the "cost-shift/hidden tax" burden is placed on all of our others payers, such as auto insurance companies through auto no-fault, and commercial insurers through higher employer-sponsored health insurance premiums.

I understand that in previous weeks, a spreadsheet was being distributed showing a comparison of payments made by auto no-fault, Medicare and Worker's Compensation. This caused many of you to feel that such disparity was not "fair." It is my hope that through my explanation and the illustration on the screen, you now have a better understanding of why this "cost-shift" occurs. It is also my hope that as state lawmakers you will avoid the temptation to criminalize health care providers – as some groups have suggested - for "taking advantage of auto no-fault." Instead, I hope you have a greater appreciation for recent history and how your predecessors in the Legislature have contributed significantly to this reality through the handling of the state Medicaid budget.

None of you on this Committee today serve on the House Appropriations Subcommittee for the Department of Community Health. In fact, many of you probably specifically asked not to be appointed to that committee. However, you will recall that earlier this year when Governor Snyder submitted his proposed FY 2012 budget to the Legislature, he did so proposing no Medicaid rate reductions to providers. This seemed amazing to many due to the fact that since FY 1996 Medicaid rates have been cut by more than $1.1 billion. Governor Snyder's understanding of this broken part of the state's Medicaid program remained consistent through the budget process and the Legislature passed a plan that avoided a rate reduction. A Medicaid payment increase would have been nicer, but we commend all of you who supported the Governor's budget and protected the Medicaid rates that support health care delivery by your community physicians and hospitals.

This now brings us here to today's discussion of reforming Michigan's auto no-fault system. While auto insurance companies are looking for ways to reduce their rates and their medical expenses, the health insurance benefit in today's auto no-fault system has been in place for the past 35 years and is funded purely through the personal responsibility of individuals who are assuming the risk of being a motorist. This health care benefit is NOT paid for by our employers, nor our neighbors through a government program.

Some have testified that that "unlimited" health care benefit in auto no fault is the only of its kind and cannot be found in other insurance products. That assertion is false. While I have established that Medicaid and Medicare do not pay providers enough to cover the costs of care, these two programs contain no limits to the amount of covered health care services you can access, and therefore would also be "unlimited." Additionally, during the federal health care reform debate of the past few years, the new law also includes a provision that prohibits all commercial health insurance companies from having annual or lifetime limits.

The proposed changes in House Bill 4936 will do nothing to reduce the number of Michigan motorists who will be injured in auto accidents and therefore need health care services. Rather, dismantling the current auto no-fault system will simply cost-shift the personal financial responsibility away from the motorist and auto insurance companies. As injured motorists deplete all of their more limited medical auto insurance benefit, four things will occur; they will (1) shift their expenses to any available employer-sponsored health care; (2) exhaust their personal assets; (3) create a field day for some trial attorneys by filing lawsuits against at-fault drivers; and lastly (4) find themselves eligible to enroll in the state's Medicaid program.

(To complete the illustration) To reform auto no fault as is currently being proposed, will only put more pressure on the state government and taxpayers through increased judicial and Medicaid costs, and creates upward pressure on health care rates charged by health care providers, which in the end translates into a larger financial burden on the business community through higher health insurance premiums. To highlight how control measures are put in place to keep health care costs low, my colleague Larry Oberst will offer some additional insights.

[LARRY OBERST's COMMENTS]

Thank you Mark, and I too would like to thank the committee for the opportunity to speak with you today. Again, my name is Larry Oberst and I am the VP of Finance for Spectrum Health Continuing Care. Continuing Care houses all of the post-acute services provided by Spectrum Health, such as long-term care, homecare, hospice and palliative care, rehab and three specialty programs to treat patients/residents who have suffered traumatic brain injuries (TBI). Many of the TBI patients that we treat suffered their injuries in an auto accident and their treatment is therefore substantially paid for through the auto no-fault Personal Injury Protection coverage.

I would like to make a few comments about Spectrum Health's experience working with the auto insurers. Spectrum Health, like the auto insurers, understands the need to control the cost of health care while still maintaining quality. This is especially important for our most seriously injured, long-term

auto no-fault patients and residents. To this end, Spectrum Health has made the investment to have their TBI programs accredited by the Committee on Accreditation of Rehabilitation Facilities (CARF). CARF accreditation confirms to the auto insurers and other payers, that the provider has demonstrated a quality of care and outcomes that is both clinically and financially responsible. It provides a higher level of accountability to all concerned parties (health care provider, patient and payer).

Beyond our CARF accreditation, many of the large auto insurers utilized either internal or external care managers to actively monitor the type and intensity of health care services being provided to their insured. This is an active, collaborative process between the care manager and the health care provider to ensure that the right health care services are being provided at the right time and in the right health care setting. This is an effective step in keeping health care costs down and helps prevent abuse and/or fraud.

Unlike what you might have heard, not every auto insurer pays our full charges for our health care services. We have, in fact, negotiated discounts with many of the larger auto insurer payers whereby they pay a negotiated rate (such as a percent of charges). It's most of these same insurers with whom we've negotiated discounts that also utilize case managers.

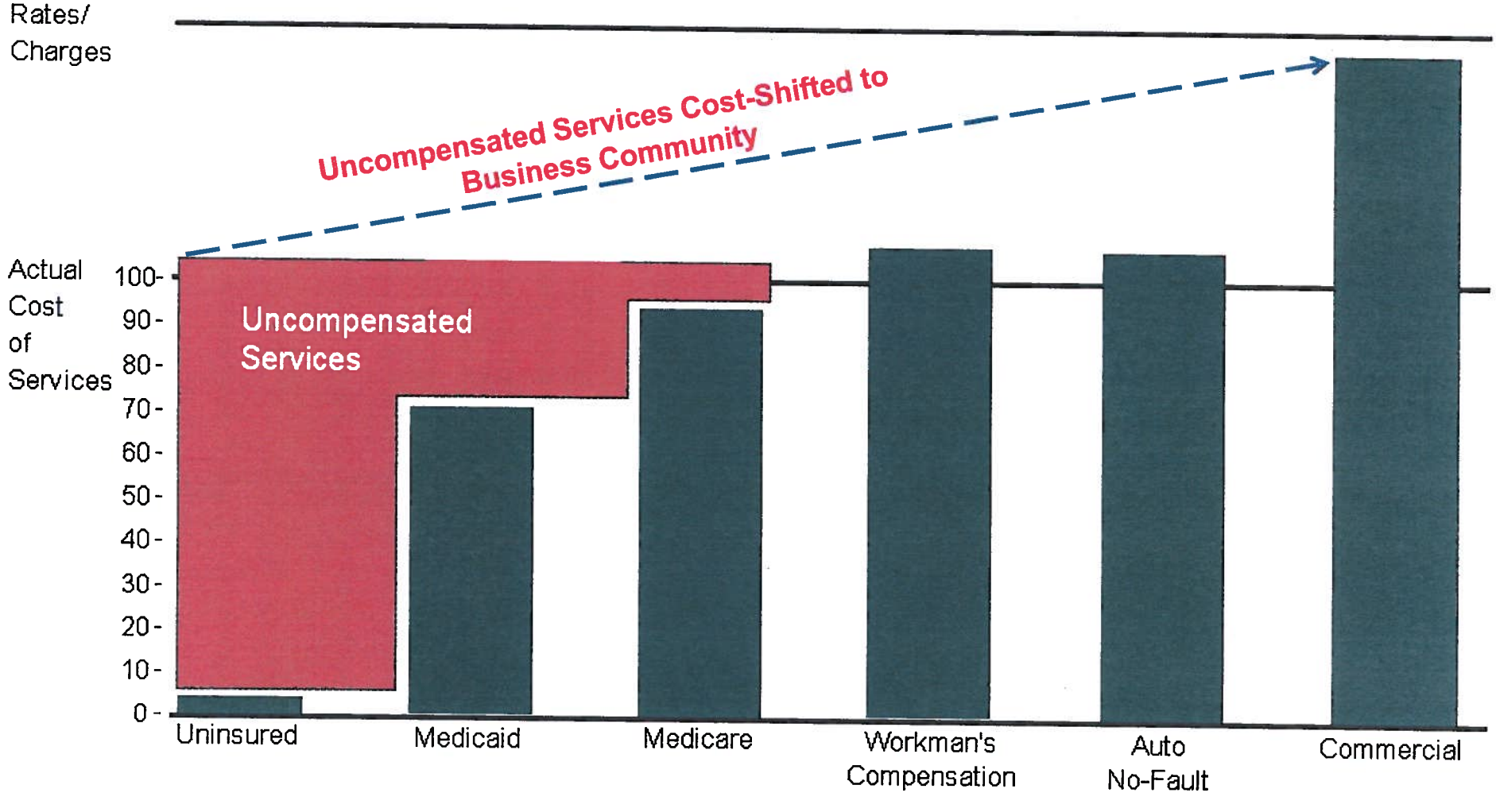
Finally, while we've spent much of our time talking about the financial side of health care and this bill, we have to keep at the forefront of the discussion the fact that we are dealing with real people with traumatic and often life changing injuries. We believe that this bill, as currently written, will limit the access to care for these seriously injured victims. It will not give them the opportunity to achieve their highest level of functionality and independence, to be at home with their families again. Rather, if this bill were to be enacted, it is more likely that they will remain a resident within the health care system, paid for by the Medicaid program. In addition, reduced reimbursements by virtue of mandated fee schedules will likely put some health care providers in financial peril which will limit access for all of the residents of Michigan while compromising the quality of care we've come to expect.

[BACK TO MARK]

In closing, thank you for the opportunity to come before you. We appreciate the objective that is trying to be achieved. Spectrum Health is pleased that many of you recognize the current version of this bill still needs to be improved upon. Therefore, we are committed to continuing to work with you and other stake holders to develop solutions that can present more of a win-win solution for auto insurance, health care providers and most importantly Michigan residents. We respectfully ask that the process of deliberation remain in the Committee and that the bill not be moved to the House floor.

[DEFER TO ANDY FOR GRACC's COMMENTS]

Operational Payer-Mix / Cost-Shift Dynamics



Second, if the first question is true, then what can be done to correct the problem while still providing a level of protection for catastrophic victims and their families that we have come to appreciate here in Michigan? As Independent Agents, our members have always sought to consider our insurance customers as we consider pending legislation and its impact.

To share MAIA's position with comment, I would like to turn it over to Mike McBride. Mike is MAIA's current President, a licensed agent, and comes from Mason-McBride Insurance from Oakland County.

Mike McBride:

Thank you, Mr. Chair and Committee Members.

The MAIA Board unanimously adopted the following position regarding the proposed no-fault reform elements of HB 4936:

- MAIA supports a fee schedule; Almost the entire medical provider community operates under some form of schedule (Medicaid, Medicare, Workers Comp, Blue Cross). It is not unreasonable to formalize such a schedule with respect to Auto No-Fault. However, we encourage you to think outside the box with respect to a fee schedule. Accessibility issues and comparisons between a worker's comp and catastrophic injuries have been raised. Hope Network's use of a discounted schedule for timely payment is one example. Post Trauma care would be another.

- MAIA supports compromise language between the Kreiner and McCormick case thresholds; Chief Justice Robert Young of the Michigan Supreme Court has called for clarifying language for non-economic or pain & suffering criteria.

- MAIA supports attendant care cost containment measures;

- Rather than the proposed PIP Choice levels, MAIA supports a single-limit Personal Injury Protection (PIP) coverage of not less than $1 million; MAIA is concerned with the PIP Choice element and that the $250,000 limit would become the "de facto" level of insurance resulting in consumers being underinsured in the event of a catastrophic injury accident. In fact, the Anderson Economic Group

testified that 90% of the insured's would move to the lower limit and another stated that in those states that offered PIP Choice, 80% - 95% moved to the lower limit. That would result in 575 – 675 catastrophic victims being underinsured each year according to the AEG numbers;

Agents are on the front lines. They have or have seen enough clients that have exceeded the $250,000 low PIP limit. They have not seen that many greater than $1,000,000. Is there something magical about the $1M mark? No. We don't claim to be the expert in what a cap would be. You have heard from at least one individual that has exceeded that amount. However, the $1M mark would cover all but 2 people each year involved in catastrophic accidents. (According to AAA's testimony, $1M covers 99.68% of all claims; .0032 x 700 catastrophic accidents (AEG average) = 2.24.)

Estimates of the savings to consumers should this proposal pass amount to little more than the MCCA assessment of $150/year in return for giving up the best coverage (and probably the best care) in the world. That works out to about $12/month or $.40/day.

We have some additional concerns with the PIP Choice proposal (listed in our written testimony) but for the sake of time I will skip over them:

- Initial savings degenerate over time as costs shift to cover increased liability in additional lawsuits - thus, consumers will/may pay the same for less benefit;
- Costs will shift from insured to the state of Michigan as those who choose low limit turn to state benefits such as Medicaid to pay for catastrophic injuries;
- With Michigan's financial picture still hazy, moving from a "private" to public financing scheme for catastrophic victims seems ill-timed;
- The consumer could experience degradation in medical care if handed-off from auto insurance to public medical care coverage like Medicaid or Medicare;
- Agents have numerous examples of auto accident victims who were saved financially because of Michigan's No-Fault Law;
- The residents of Michigan have twice expressed their will at the polls in the 1990s regarding no-fault reforms by voting to maintain the current provisions;

- The actual savings is primarily due to not paying the MCCA assessment and, thus, not receiving the significant protection benefit; Consumers give up significant medical protection and benefit for the approximate savings of a little more than the MCCA assessment, currently about $150;
- With a choice option, E&O costs may rise as agents are subject to more lawsuits if insured chooses a lower limit and is then involved in a serious accident; Even if Agent Immunity Language were present, protection does not prevent a lawsuit from being initiated;
- The Federal Health Care law may significantly alter Michigan's PIP requirements. All will be able and required to purchase health insurance without lifetime limits on the policy. Michigan's PIP requirement may become duplicative of the federal mandate.
- The question must be asked, if Michigan ranks 10th in cost with the best benefit in the country, then why are other states more expensive on average than Michigan? If other states have nowhere near the benefit of Michigan, what are they paying for? Texas and Florida slightly less; Louisiana, Alaska, Nevada, and several East Coast, New England states higher (9 in all).

We believe our first three points help to maintain the financial integrity of the MCCA. Our last point protects what we believe was the intent of Michigan's no-fault law and offers continued consumer protections for Michigan's insured drivers.

Some additional policy questions you may want to consider: What was the intent of the Legislature when they passed No-Fault? What problem were they trying to solve? Has it accomplished its purpose? Would the changes you are considering with HB 4936 preserve those solutions or recreate the problem(s) they were intending to address? If the changes may recreate some of the issues that no-fault was originally designed to alleviate is there another option or level of coverage that might address the concerns of the proponents yet not recreate past problems?

We understand that it is always appropriate to examine and consider if a law passed by a previous legislature has accomplished its intended purpose(s) and also to examine if changing circumstances necessitates changes to the law to keep its intent. In this case MAIA believes that there

are reasons to consider amending our current no-fault law to strengthen the long-term outlook for the MCCA, as we have indicated, and maintain the robust and beneficial coverage that Michigan drivers enjoy. However, we would encourage you not go so far as to recreate problems that caused the previous legislature to act in the first place, that is allow for coverage too low whereby consumers are left to other means by which to receive benefits to treat their catastrophic injuries.

We don't have to be ashamed of Michigan's no-fault law; that somehow we are not like other states. We do have to make sure that we do what is necessary to ensure the financial integrity of the MCCA and no-fault law in order to keep our great example for Michigan's insured drivers.

MAIA wishes to thank you Mr. Chairman, for recognizing the risk to agents and for including the language that offers a degree of protection for agents should the PIP Choice element of the bill become law. Thanks also to the committee for your time and we are available for any questions you may have.